STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385217	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsboro Health & Rehabilitation Center	1778 NE Cornell Road Hillsboro, OR 97124

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38140 Based on observation, interview and record review it was determined the facility failed to develop a resident centered care plan for 1 of 1 sampled resident (#1) reviewed for activities. This placed residents at risk for a lack of meaningful, purposeful and preferred activities and unmet psychosocial needs. Findings include: Resident 1 admitted to the facility in 12/2023 with diagnoses including dementia. The 3/1/25 Annual MDS assessed Resident 1 with a BIMS of three, which indicated severe cognitive impairment. The MDS Activity Preferences section indicated she/he found reading materials and the news somewhat important to her/him. Music, animals, going out in the fresh air and doing her/his favorite activities were very important. The 3/25/25 Activity Progress Note: Annual Review evaluation indicated Resident 1 was independent with activities and did not get out of bed. Resident 1 enjoyed The Daily Chronicle (flyer which provides reading, puzzles, coloring pages and other reading activities) and talking to family on the phone. The evaluation indicated Resident 1 was dependent for transportation on others and the problems indicated she/he did not get out of bed. Record review of Resident 1's Activity Participation from 4/23/25 tthrough 5/21/25 revealed the resident had not attended Bingo in the past 30 days. Resident 1 was documented to participate in the reading from the activity cart in her/his room frequently. A observation and interview on 5/19/25 at 1:07 PM revealed Resident 1 had no reading materials in reach of her/him. No music or television were on and the window blinds were open. Resident 1 stated she/he had not been busy for many years and would like to get out and do something which she/he liked to do. Resident 1 stated she/he enjoyed reading murder mystery, thriller and suspense books. The resident stated she/he did not recieve books to read. On 5/20/25 at 1:49 PM Resident 1 was observed in her/his bed with no lights on in the room, the blinds were slightly open and no reading material was within reach. No music or television was on and the curtain was pulled to not enable her/him to see into the hallway. Resident 1 smiled and stated she/he was not doing anything when asked. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/25 at 10:10 AM and 2:19 PM Resident 1 was observed in bed with no reading materials in reach, no music playing, and the blinds were open. At 2:19 PM the resident waved at the surveyor in the hallway and smiled. The 5/21/25 Care Plan indicated Activity Preferences documented in the ADL section. The intervention was ACTIVITY PREFERENCES: (SPECIFY). No other information was found in the care plan to direct staff to assist Resident 1 for her/his leisure, recreational, diversional or purposeful activities. Resident 1's 5/21/25 Kardex (a in room care plan) for Activity Participation directed staff to bring the resident to bingo. No additional activity preferences documented. On 5/22/25 at 11:27 AM Staff 22 (CNA) stated they obtained their information to care for the resident from the Kardex. When asked what activities Resident 1 enjoyed, Staff 22 stated Resident 1 preferred to stay in bed in her/his room. On 5/22/25 at 12:23 PM Staff 9 (CNA) stated they obtained their information to care for residents from the Kardex. Staff 9 stated Resident 1 liked to stay in bed and family was involved. On 5/23/25 at 9:09 AM Staff 23 (Activities Director) confirmed Resident 1 did not attend Bingo as directed in the Care Plan, no refusals to attend were documented and the resident preferred to stay in bed. Staff 23 acknowledged she had personally read The Daily Chronicle at bedside for Resident 1. Staff 23 stated Resident 1 was able to read printed reading material and sometimes used a magnifier glass. Staff 23 was aware Resident 1 enjoyed to read murder mystery type books but could not recall when the Resident was last provided a book to read or opportunity listen to a talking book. Staff 23 confirmed the Kardex and Care Plan did not direct staff to provide resident center leisure or diversional activity opportunities. On 5/23/25 at 11:08 AM Staff 1 (Executive Director) acknowledged he expected all residents to have a person-centered care plan for activities and all staff should be able to provide opportunities to assist residents in meaningful activities. Staff 1 confirmed he expected Resident 1 to have additional information in the Kardex and Care Plan for activities.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46053 Based on observation, interview and record review it was determined the facility failed to provide the necessary care and assistance to maintain good grooming and hygiene for 1 of 4 sampled resident (#43) reviewed for ADLs. This placed residents at risk for poor grooming. Findings include: Resident 43 was admitted to the facility in 3/2025 with diagnoses including nephrogenic diabetes insipidus (a medical disorder that occurs when your kidneys cannot properly balance bodily fluids) and ataxia (impaired muscle control that can affect walking, balance and the coordination of hand movements). A review of Resident 43's 5/3/25 admission MDS revealed she/he was cognitively intact and required supervision or touching assistance to complete personal hygiene tasks. Resident 43's care plan dated 4/28/25 revealed she/he received maximal/substantial assistance with showers on Sunday and Wednesday evenings and required supervision/touch assistance for grooming and personal hygiene. On 5/19/25 at 11:04 AM Resident 43 was observed to have a thick cluster of dark hairs growing from her/his chin. Resident 43 stated she/he was unable to shave independently because she/he could not control her/his hand movements. Resident 43 stated she/he was supposed to receive assistance to shave on her/his shower days and asked the CNAs to assist with shaving her/his shin hairs. On 5/22/25 at 2:13 PM Staff 18 (CNA) reported he worked with Resident 43 and should have offered to shave her/his chin because she/he was unable to shave independently. On 5/22/25 at 2:16 PM Staff 9 (LPN) stated he worked with Resident 43 regularly. Staff 9 stated Resident 43 was able to hold a razor but needed cueing to pick it up. Staff 9 stated he expected CNAs to help Resident 43 to shave herself/himself because she/he was unable to shave independently. On 5/22/25 at 2:42 PM Staff 19 (CNA) stated Resident 43 was unable to shave herself/himself because her/his hands were shaky and the resident was supposed to be shaved on her/his shower days. Staff 19 stated Resident 43 was not offered to be shaved this week. On 5/23/25 at 9:21 AM Staff 2 (DNS) stated she expected Resident 43 and other residents who required assistance with ADLs to receive assistance automatically. Staff 2 acknowledged Resident 43 was not provided appropriate ADL care and Resident 43 should not have to ask for assistance.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34324 Based on interview and record review it was determined the facility failed to respond to a change of condition and provide respiratory interventions timely for 1 of 1 resident reviewed (# 41) for change of condition. This placed residents at risk for respiratory distress. Findings include: Resident 41 admitted to the facility in 2023 with diagnoses including chronic obstructive pulmonary disease (COPD), chronic kidney disease and atrial fibrillation. The facility undated Standing Orders for oxygen indicated the goal of supplemental oxygen was to maintain saturations above 89% for residents with COPD. The orders indicated oxygen may go up to 2 liters before the provider was to be urgently notified. The 10/30/23 Care Plan directed staff to monitor Resident 41 for difficulties breathing and signs or symptoms of acute respiratory insufficiency. A Facility Report Incident indicated at 7:00 AM on 12/16/24, Resident 41 was found to have oxygen saturations of 64%. Resident 41's oxygen saturations were checked an additional two more times which were below 70%. Staff 5 (CNA) informed Staff 9 (LPN) several times as well as Staff 11 (Resident Care Manager/LPN) of Resident 41's low oxygen saturations. Staff 11 indicate he was busy, and took him time to address the concern. Staff 11 acknowledged oxygen was not given to the Resident 41. The resident was not sent out of the hospital until 2:00 PM and was diagnosed with hypoxic (an absence of enough oxygen in the tissues to sustain bodily functions.) respiratory failure. The report concluded a lack of evaluation, treatment and urgency was found by the facility nurses. The report further indicated although the resident's condition may have not been prevented, an evaluation and initiation of oxygen may have provided relief and comfort to Resident 41. The 12/16/24 hospital noted indicated Resident 41 arrived at the hospital on 1 to 2 liters of oxygen. Resident 41 denied any shortness of breath, however, was found to have oxygen saturations in the low 70's at the nursing facility. During the resident's emergency department stay she/he was between 1 to 2 liters of oxygen and room air. On 5/19/25 at 9:47 AM Resident 41 stated she/he could not recall the incident on 12/16/24. Resident 41 stated she/he did not use oxygen. On 5/20/25 at 11:58 AM Staff 5 stated she was Resident 41's CNA on 12/16/24. Staff 5 stated on the morning of 12/16/24, Resident 41's oxygen saturations fluctuated between 64 to 68%. Staff 5 stated she told Staff 9 and Staff 11 of the resident's low oxygen saturations. Staff 5 stated the resident was not at her/his baseline and did not look well. Staff 5 stated Resident 41 was not given any oxygen and the resident was not sent out of the hospital until 2:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 1:12 PM Staff 9 stated on 12/16/24, Staff 5 reported to him of Resident 41's low oxygen saturations. Staff 9 stated he checked the resident and was able to get her/his oxygen levels up by gravity and had the resident take deep breaths. Staff 9 stated Resident 41's oxygen saturations fluctuated between 80 to 90 percent. Staff 9 stated the first intervention should have been to provide oxygen to Resident 41, but he did not. Staff 9 stated oxygen saturations should be at 95 percent and below 90 percent was concerning. Staff 9 stated Resident 41 was not sent out to the hospital until the afternoon. On 5/21/25 at 9:51 AM Staff 11 stated on 12/16/24 he was not informed by Staff 5 of Resident 41's low oxygen saturations until 1:00 PM to 1:30 PM. Staff 11 stated he told Staff 9 to send the resident out to the hospital. Staff 11 further stated oxygen should be administetered for oxygen saturations below 92%. On 5/22/24 at 9:51 AM Staff 2 (DNS) stated when Resident 41's low saturations were reported to Staff 9, he should have reassessed Resident 41 and the first intervention should have been to provide the resident with oxygen. Staff 2 stated the standard of practice was to complete a full set of vitals, implement appropriate interventions, make a determination and either send the resident to the hospital or contact the physician if the resident was not in distress. Staff 2 acknowledged Resident 41 was not provide appropriate and timely respiratory interventions on 12/16/24.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46053 Based on interview and record review it was determined the facility failed to conduct weekly skin observations and evaluations to identify pressure ulcers and administer treatments timely treatment for 1 of 3 sampled resident (#359) reviewed for pressure ulcers. This placed residents at risk for complications related to unavoidable skin breakdown and not receiving care to treat pressure ulcers in a timely manner. Findings include: Resident 359 was admitted to the facility in 3/2024 with diagnoses including Alzheimer's disease (a progressive disorder which primarily affects the brain and leads to cognitive decline) and diabetes mellitus. A review of Resident 359's 3/18/24 admission MDS revealed she/he had severe cognitive impairment, had pressure ulcers, was at risk for the development of additional pressure ulcers and was dependent on staff for bed mobility. The Pressure Ulcer/Injury CAA indicated the facility provided Resident 359 with a pressure relieving mattress for her/his bed to minimize the pressure on her/his bony prominences while in bed. Resident 359's 3/22/24 care plan related to her/his pressure ulcers and risk for further skin breakdown indicated staff were to reposition her/him frequently, inspect her/his skin while providing cares and notify the nurse of any new skin conditions. A review of Resident 359's Weekly Skin Observations revealed no new skin impairments were identified on 8/7/24, 8/20/24, 8/30/24 or 9/13/24. The next reported Weekly Skin Observation was completed 35 days later on 10/17/24 and indicated Resident 359 developed an irregularly-shaped unstageable pressure ulcer (obscured full-thickness skin and tissue loss) 8 cm long and 10 cm wide on her/his coccyx (the last bone at the base of the spine). A hospice bath aide progress note dated 8/23/24 indicated Resident 359 had a new open sore on her/his bottom. Staff 11 (Resident Care Manager/LPN) signed the note and indicated, noted. A review of the facility's 10/16/24 investigation of Resident 359's open wound revealed the following: -A skin assessment completed on 10/15/24 indicated Resident 359 had an unstageable coccyx pressure injury with a dressing covering the area; -There was no previously written order for a dressing to be placed; -A coccyx pressure injury was noted on 8/26/24 in a hospice progress note and indicated Will fax new wound care orders; -The treatment order for the coccyx pressure injury was received on 9/20/24 but was implemented or followed up on; and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility determined there was a breakdown regarding the skin/wound management process and lack of nurse follow up regarding orders. A 10/18/24 progress note created by Staff 3 (RNCM) indicated Resident 359's coccyx pressure ulcer appeared to be a terminal ulcer. On 5/21/25 AT 4:18 PM Staff 3 stated the initial wound was discovered on 8/23/24 and a new wound dressing order was placed on 8/26/24 but was overlooked and not implemented. Staff 3 stated she first observed Resident 359's coccyx pressure wound on 10/18/24, noting it was a larger wound at the time and was then identified as a [NAME] pressure ulcer (a type of pressure ulcer that rapidly develops in the final stages of life, often appearing on the coccyx or other bony prominences). On 5/22/25 at 2:33 PM Staff 20 (LPN) stated Resident 359's hospice provider visited her/him twice each week, checked her/him for any changes and asked CNAs if there was anything new. Staff 20 stated CNAs repositioned Resident 359 every two hours due to the resident's fragile skin. Staff 20 stated Resident 359's hospice caregiver discovered the new wound on resident 359's coccyx during a regular visit but he did not recall the date. On 5/22/25 at 2:48 PM Staff 19 (CNA) stated Resident 359 required assistance from two staff to reposition because her/his skin was fragile and she/he was limp and unable to help the CNAs with the repositioning process. Staff 19 stated she was aware of Resident 359's multiple pressure ulcers but was unaware of any new pressure ulcers to the resident's bottom. On 5/22/25 at 4:33 PM Staff 11 stated on 8/23/24 Resident 359's hospice provider observed a new open wound on the resident's bottom which was not previously observed or charted by staff in Weekly Skin Observations. Staff 11 stated hospice staff left him a handwritten note regarding the new wound. Staff 11 stated he did not act on the note because he had been out of the facility for more than a week, he did not ensure the information was provided to the oncoming nurse and instead assumed a nurse would see the note. On 5/23/25 at 8:53 AM Staff 21 (Former Administrator) stated Resident 359's hospice provider stated they faxed orders to treat the new pressure wound identified on 8/23/24 but the orders were not received and the resident was not provided care for the new wound when. Staff 21 stated the wound on 8/23/24 was blanchable (a type of pressure injury characterized by intact skin with a localized area of redness that turns white when pressed with a finger). On 5/23/25 at 9:29 AM, Staff 2 (DNS) stated she worked as the Regional Support Nurse during Resident 359's stay. Staff 2 stated staff were required to complete Weekly Skin Observations, which would trigger weekly skin evaluations for any new wounds. Staff 2 stated staff were expected to obtain and implement treatment orders for new skin impairments, maintain consistent wound care documentation, and follow facility protocols. She acknowledged staff's failure to document Resident 359's skin condition and follow up on orders, which led to inadequate evaluation and delayed treatment. Staff 2 stated Resident 359's pressure ulcer was discovered by hospice on 8/23/24, before facility staff identified the wound. Staff 2 further stated regular observations and documentation should have identified the new skin impairment to enable timely treatment and prevent wound deterioration.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41458 Based on interview and record review it was determined the facility failed to ensure the Direct Care Staff Daily Report (DCSDR) postings were accurate for 5 of 7 days reviewed for RN staffing. This placed residents and visitors at risk for inaccurate staffing information. Findings include: A review of the facility's DCSDRs on 5/1/25, 5/5/25, 5/6/25, 5/7/25, 5/12/25, 5/13/25 and 5/14/25 revealed the postings inaccurately reflected the facility's RN coverage on the following days: -5/5, 5/6, 5/12, 5/13 and 5/14. On 5/22/25 at 12:15 PM, Staff 14 (Staffing Coordinator) confirmed the facility's DCSDRs inaccurately reflected RN coverage on 5/5/25, 5/6/25, 5/12/25, 5/13/25 and 5/14/25.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 41458 Based on interview and record review it was determined the facility failed to provide appropriate dosing of opioid medications for 1 of 6 sampled residents (#45) reviewed for medications. This placed residents at risk for complications related to narcotic medications. Findings include: Resident 45 was admitted in 3/2025 with diagnoses included alcoholic cirrhosis of the liver (severe liver disease) with ascites (abnormal build-up of fluid in the space between the organs and the lining of the abdomen). Resident 45's 4/17/25 physician order indicated the resident was to be administered two tablets of oxycodone (opioid pain medication) every four hours as needed for pain levels of eight to 10 out of 10. Resident 45's 5/2025 MAR indicated the resident was administered two tablets of oxycodone when her/his pain levels were less than eight as follows: -5/1: for pain levels of 6 and 7. -5/2: for pain levels of 5 and 6. -5/3: for pain levels of 4 and 5. -5/4: for pain levels of 5 and 6. -5/5: for a pain level of 6. -5/8: for pain levels of 4 and 5. -5/7: for a pain level of 7. -5/8: for pain levels of 4 and 5. -5/9: for a pain level of 7. -5/10: for a pain level of 6. -5/11: for a pain level of 7. -5/12: for a pain level of 5. -5/14: for pain levels of 6 and 7. -5/16: for a pain level of 6. -5/18: for a pain level of 5. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/19: for a pain level of 3. -5/20: for a pain level of 7. -5/21: for a pain level of 7. On 5/19/25 at 9:20 AM, Resident 45 stated she/he had back pain and they keep putting me on opioids when the muscle rub worked better. Resident 45 stated staff were more strict with the muscle cream than the opioid medication. On 5/21/25 at 2:27 PM, Staff 9 (LPN) reviewed Resident 45's MAR and stated on 5/9/25 and 5/16/25 he did not ask Resident 45 her/his pain level because the resident would just state 10 if asked so he always dispensed two oxycodone pills to the resident. Staff 9 stated he just recorded a number in the pain level section and should have recorded an eight. On 5/21/25 at 2:34 PM, Staff 17 (RN) reviewed Resident 45's MAR and stated on 5/11/25 she mistakenly administered two oxycodone pills when she/he should have administered one pill. On 5/22/25 at 8:15 AM, Staff 8 (LPN) stated Resident 45 usually experienced pain and was clear in communicating if she/he was painful. Staff 8 reviewed Resident 45's MAR and stated on 5/3/25, 5/4/25, 5/5/25 and 5/8/25, she administered two oxycodone pills when only one oxycodone should have been administered. On 5/22/25 at 8:27 AM, Staff 3 (RNCM) reviewed Resident 45's MAR and confirmed the resident was administered two oxycodone pills when she/he should have received one pill on the identified days. On 5/22/25 at 8:44 AM, Staff 2 (DNS) stated physician orders should be implemented and followed. Staff 2 acknowledged staff did not follow the parameters for the administration of Resident 45's oxycodone.